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A CASE OF EMPYEMA TREATED BY FREE INCISION. DEATH. AUTOPSY.

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APRIL 5, 1874.—C. P., aged 19, pattern maker. Has always been healthy until a year ago, when he caught a severe cold, which lasted a long time, and was accompanied with pain in right chest. No hereditary disease in family. After recovering from this cold, went to work again, and was in pretty good health until about three months ago, when he took cold after exposure, and had severe pain in right side, sharp and darting at first, more dull afterward. At this time, began to be feverish, and to grow weak, having pain in right chest nearly all the time; his appetite and strength failed rapidly. He continued to grow worse, and took to his bed about six weeks ago, and has remained there ever since. Emaciation has been rapid, and cheeks marked with hectic flush. During the past two weeks, he has been sweating profusely, night and day. He has had beef-tea, chicken broth, &c., and whiskey to the amount of a pint daily.

The case has been considered acute phthisis, and treated as such. I saw him to-day, for the first time. He lies in bed upon his right side, breathing with difficulty. He is greatly emaciated, the hip bones and shoulders being covered only by skin; there is a bed-sore upon right hip, and another upon right shoulder. He is too weak to move without help. Coughs a great deal, raising large quantities of frothy pus and mucus. Physical signs:—Left lung hyper-resonant, with exaggerated respiratory sounds. Left lung, as far as I could get at it, was perfectly flat over the whole front and side, with entire absence of respiratory sounds. Any attempt to turn him upon his back, or upon the left side, brought on such excessive dyspnœa and coughing that I contented myself with a slight examination. The fact of his lying continually upon the right side made me suspect that there might be fluid there, but I did not verify my suspicion, and rather inclined to the belief that the air cells of the right side were completely blocked up with tubercle. Ordered sponging frequently with rum and alum, and

℞. Calcis phosphat. gr. xv. every night.
℞. Acidi hydrocyan. gtt. j.
Ext. pruni virg. fluidi ℥j. every four hours.

Diet to be as nourishing as possible; chiefly, strong beef-tea in small quantities frequently. Milk punch, containing two fluidounces of whiskey, every four hours; also whiskey and water occasionally.

April 12th.—Sweating ceased entirely three days ago. For the past two days, has been delirious, tossing about and talking incessant-

ly. To-day, is more quiet, though still excited and talkative; face flushed, skin hot, pulse 120, of moderate strength. Physical signs the same as on last visit. Above the right nipple, is a rounded swelling, not tender, and the tissues between nipple and axilla are swollen. Continue treatment.

April 15th.—Found patient moved from the bed to the sofa, and had an opportunity to make a more extended examination of thorax. He had just coughed up about a pint of fœtid, brown pus mixed with mucus. As he lay on the right side, I found tympanitic resonance over a small portion nearest the sternum, the line of flatness commencing about the middle of right clavicle, and passing directly downward. Very feeble respiration could be detected in the resonant portion. There was a blowing sound beneath the swelling above mentioned, and upon pressing it with the fingers, an emphysematous crackling was heard. The left lung was the same as on the first examination. From these signs, I concluded that there was a large collection of fœtid pus in the right pleural cavity, and an opening in the lung itself near the apex.

Pulse 120, and of moderate strength. Has diarrhœa. As he continued to be very restless, and at times delirious, constantly talking and tossing about, I diminished the allowance of whiskey to four ounces per diem in milk punch.

April 18th.—Consultation with Dr. M. E. Webb. Signs same as yesterday. The bulging between ribs was very marked, and fluctuation could be detected. The excitement is rapidly diminishing, and he takes a fair amount of beef-tea, milk, &c. Slight diarrhœa continues. Pulse 116. Temp. 101·8°. Resp. 32.

April 19th.—With Dr. Webb's assistance, tapped with aspirator between seventh and eighth ribs, about two inches from the lower angle of scapula toward the middle of the ribs, and removed three pints of brown, fœtid, thick pus; the pus was very frothy. He had coughed up a pint this A.M., before the operation. I had intended to make a permanent opening at this visit, but his excessively feeble condition and nervousness decided me to try the aspirator first, in hopes that he would gain strength and courage to undergo a severer operation. After the pus was removed, he lay upon his left side for the first time in five weeks. In about half an hour, I applied the stethoscope, and found feeble respiration over the greater part of the lung.

April 20th.—Slept pretty well last night. About 3, A.M., had a chill, not very severe, lasting a half hour. This has not occurred again, and he feels quite comfortable. Pulse 106. Temperature 100·2°. Respiration 25. Cough not troublesome. Has taken some beefsteak, and three or four cups of milk this forenoon. Bowels still rather loose.

Resonance pretty good over most of lung; flatness over a portion of the most dependent part, where there is no respiration, and a slight bulging of intercostal spaces. Emphysematous crackling upon pressing tissues between nipple and scapula. Continue nourishing treatment.

April 22d.—Passed a comfortable day yesterday; ate beef-steak and stewed pigeon. Diarrhœa ceased. This A.M., had a fit of coughing, and raised a considerable amount of brownish pus. Since then, has felt weak and nervous. Has a good appetite, and has had steak and beef-tea to-day. Lies upon back without discomfort, and has maintained this position all the forenoon. Pulse 116. Temperature 99·6°.

April 23d.—Passed a pretty comfortable night. Has been coughing a good deal this A.M. Is prepared to undergo the operation for permanent drainage. *Operation*, Dr. M. E. Webb assisting. A knife was passed between the eighth and ninth ribs, about an inch to the right of the lower angle of scapula, into the pleural cavity, and the incision slightly enlarged on withdrawing the blade. No pus escaped. An India-rubber drainage-tube was then pushed in about five inches, and secured by straps of adhesive plaster. The pump of the aspirator was attached to the tube, but no pus could be drawn through. After injecting a little warm water, without helping matters, the tube was drawn out, clots removed from its calibre and re-introduced, but still no pus could be drawn through it. Tube was removed, and a canula introduced, but with no better result. As the patient was growing very weak, crying out with pain, and threatening to faint, the canula was removed, and a poultice applied over incision. A little whiskey and water was given. He coughed incessantly, without raising anything. Pulse 116. Temperature 100·6°.

℞. Morph. sulph. gr. ⅛ statim, to be repeated in half an hour, if coughing continues. Also, if he has a chill to-night, to have morph. sulph. gr. ⅛. Continue supporting treatment.

April 24th.—Had a slight chill about 2, A.M., lasting half an hour. Has taken a large amount of beef-tea and mutton broth since yesterday. Pulse 105, steady. Temperature 99·8°. No pain. Scarcely any pus has exuded into the poultice. The area of resonance does not seem to diminish. There is dulness, and absence of respiratory murmur over an area bounded by lines drawn directly downward from the anterior and posterior edges of axilla, as he lies "canted" considerably toward right side. I can find no evidence of solidification other than that caused by the fluid.

April 25th and 26th.—Condition remains about the same. Pulse 110. Temperature 99·6°. Has had no more chills. Has had two fits of coughing, each lasting about an hour, and at each attack he raised nearly a pint of frothy, brown pus. He takes plenty of nourishment, beef-tea, steak, oysters, &c., and egg-nog, containing about an ounce of whiskey, three times a day.

April 27th.—This A.M., about 11.30, found him coughing incessantly, without expectoration. Was told that this had been going on for two or three hours. He was greatly exhausted and distressed. Had not slept much during the night. Gave morph. sulph. gr. ¼, which relieved the cough in a half-hour. I decided to make an incision between the ribs large enough to allow free exit to pus, and also to administer ether, which I had been afraid to do before, on account of his feeble condition, and the absence of respiration on the right side.

April 28th.—*Operation*, Drs. Webb and Everett assisting. Ether was carefully given by Dr. Webb, and patient was wholly under its influence in twenty minutes, breathing easily. I then thrust a trocar between the seventh and eighth ribs, at the point where I had found pus on the 19th inst. As pus began to flow through the canula, I removed it, and made an incision three inches long through the skin, the point of puncture being at the middle of the incision. A careful dissection was carried down to the pleura, and the pleural cavity opened by an incision of two and one-half inches. About three pints of fœtid pus escaped. On examination with the finger, a long, smooth line of

adhesion was found a few inches below the incision, passing downward and backward, evidently the bottom of the sac of the abscess. Upward, the finger could be moved freely about without finding any adhesions. The patient recovered from the ether very well. Before operation, pulse 116; temperature 99·6°. After operation, pulse 120; temperature 99·6°.

As the pulse was quite feeble, an ounce of whiskey was given in water, and the pulse soon increased in strength. There was but very little nausea, and but slight coughing. Poultice to be applied to wound. Whiskey, ℥i. every hour until next visit.

April 29th.—Had a restless night. Complains of pain in wound. The bed-sore upon the right hip seems to cause him much pain, although it is now quite small. He has taken a pint of strong beef-tea since last record. The discharge was very free during the night, and is now gradually diminishing. Wound looks healthy, but the tissues below it are swollen and tender. Has had no chill. Coughed some last night, but this ceased on taking morph. sulph. $\frac{1}{4}$ gr. Coughing causes excessive pain in wound. Continue treatment as regards diet. For stimulant, to have egg-nog, containing half an ounce of whiskey, three times a day. Pulse 106. Temperature 100·8°.

April 30th.—Had a restless night, coughing a good deal, raising pus. Appetite good; eats beef-steak, and digests well. The discharge from wound is abundant, and not fœtid. Pulse 116, not very steady. Temperature 100·4°.

May 1st.—Discharge abundant. Pulse 100, steady. Temp. 100·3°.

May 2d.—Condition about the same. Appetite ravenous. Pulse 105. Temperature 100·4°. Omit morphia entirely. ℞. Chloral hydrat., gr. xv. nocte.

May 7th. Gets some sleep every night after taking the chloral. Appetite continues good, and he takes abundant nourishment. Cough troubles him very much, and he raises brown pus, mixed with sticky mucus. For the past two days, I have been trying to introduce a drainage-tube, for the purpose of syringing out the cavity, but cannot find the opening, which seems to have granulated over. I suspect there is a collection of pus in the thorax, which does not escape, and which is keeping up the temperature and causing cough. The temperature, since last record, taken daily, has been 100·2°, 100·2°, 100·3°, 100·4°, 100·6°. The pulse has ranged between 105 and 120.

May 8th.—Coughs badly, but seems to be gaining strength. Can raise arms above his head, and lift a cup to his lips. Bed-sore on shoulder has healed, and that on hip very small. I cannot find the opening into the thorax with the probe, although the wound discharges freely into the poultice, the pus being light-colored, and without much odor. Pulse 120. Temperature 100·6°.

May 9th.—Patient etherized by Dr. Webb. On introducing the finger, I found the opening through the pleura entirely closed by granulations. The union was easily broken up with the finger, and an opening made the length of the original incision. Not much bleeding. About a pint and a half of excessively fœtid pus escaped. A rubber tube was then inserted, and the cavity thoroughly syringed out with warm water, containing a trace of carbolic acid. The tube was then fastened in by adhesive strips. Patient rallied well from the ether. Pulse, before ether was given, 122. Temperature 100·6°.

8, P.M.—There has been an abundant discharge from the wound. Patient has been restless all day, thirsty and hot. No chill. Coughs a good deal. Pulse 124. Temperature 103·2°.

℞. Spts. æther nitrosi, ʒss. in water every four hours. May drink cold water freely, and suck cracked ice. To have a glass of ale during the night, and a pint of beef-tea.

May. 10th.—Had a pretty fair night after taking chloral, gr. xv. Pus discharging freely through tube and incision. No chills. Had beef-steak and egg-nog for breakfast. Pulse 120. Temp. 101·2°.

May 11th.—Improving. Appetite very good. Washing out the thorax with warm water relieved his cough somewhat. Pulse 116. Temperature 100·6°. ℞. Quiniæ sulph., ferri sulph., āā gr. ij.; syr. aurantii, gtt. xx.; aquæ ʒi., in water three times a day.

May 16th.—Seems to gain strength, but pulse continues rapid, ranging between 118 and 120. Temperature, since last record, has been 100·2°, 100·6°, 100·6°. To-day, at 3, P.M., I find him weak from excessive coughing. Expectoration consists of frothy mucus, without pus. Pulse 124. Temperature 103.

May 17th.—Consultation with Dr. H. I. Bowditch. Dr. Bowditch thought there was a chance of saving the patient, provided the appetite continued good. He advised having the patient sit up in bed occasionally, and the internal administration of fusel oil. The thorax was washed out as usual, the tube removed, and exploration made with a catheter, which passed in about eight inches without meeting any obstruction. The tube was then replaced. Patient coughs a great deal, and this is most relieved by morphiæ sulph., gr. $\frac{1}{8}$ twice a day. The thorax is washed out with warm water every morning. Pulse 124. Temperature 102·4°.

May 18th.—Pulse 108. Temperature 101·3°. Propped him up into a sitting posture while washing out thorax, and he remained so for about fifteen minutes without feeling faint. Omit the iron and quinine. ℞. Fusel oil, gtt. v.; syr. simplicis, ʒi. M. three times daily.

May 19th.—Pulse 118. Temperature 102·2°. Sat up in bed, with a chair for support, for half an hour, during which time thorax was syringed out.

May 20th.—Pulse 120. Temperature 103·1. Coughs badly, and there are streaks of blood in the sputa. Appetite not so good as usual. Omit fusel oil, and take iron and quinine in solution āā gr. ij. thrice daily as before. Thorax to be syringed out twice a day.

May 21st.—Pulse 124. Temperature 104°. Had been coughing for two hours before visit.

May 25th.—Not doing well. Pulse, since last record, has been 120 to 124. Temperature not taken, on account of thermometer breaking. Complains of pain, on coughing, at middle of seventh rib on both sides. Physical signs remain about the same as last record. The family tell me that there has been a sudden increase in the amount of pus discharged. This A.M., they found the rubber bag, which was attached to the tube to catch the pus, and which held about three ounces, full and running over, and about a quart of pus in the bed. Patient is losing appetite gradually, and there is slight œdema of feet and ankles. This A.M., a slight diarrhœa commenced. Ordered to omit all attempts at sitting up, and thorax to be syringed three times a day.

May 26th.—Pulse 128. Temperature 101·3°. Discharge excessive,

amounting to about a pint in twenty-four hours, and very fœtid. Appetite still failing. Œdema of feet and legs increasing. No diarrhœa. Abdomen swollen and tympanitic. No pain in abdomen. Not much cough. Has a pyæmic look.

May 27th.—Pulse 134. Temperature 100·2°. Complained of great pain at a point near and a little below incision, on being syringed out this A.M. The area of dulness has increased below line of incision, and moist râles are heard all over lower half of front (right side). Also a few moist râles on left side, but no dulness on percussion. He took about half a pint of beef-tea last night, and a bowl of bread and milk this A.M.

May 29th.—As the drainage-tube seemed to cause much pain, it was removed to-day, and the cavity syringed by passing the nozzle of Davidson's syringe through the wound. He has no chills, but pulse keeps high and unsteady, and his appetite fails more and more every day.

He continued to grow worse every day, the œdema of feet and legs increased, and appetite failed completely. On June 7th, he complained much of pain in left side, and on that day diarrhœa set in. The respiration became more and more embarrassed; on June 9th, he lay in a semi-stupid state, from which he could be aroused without difficulty; he died on the morning of June 10th.

Autopsy six hours after death. Body very much emaciated. Rigor mortis not very marked. On dissecting back the skin over thorax on the right side, the intercostal muscles between the five upper ribs were found atrophied to a membranous condition, and perforated with many apertures, allowing air to escape beneath the pectoral muscles, which accounted for the emphysematous swelling before mentioned. The heart was somewhat flabby, otherwise normal. In the left pleural cavity was about a pint and a half of clear serum. The left lung was adherent posteriorly, not very firmly, from the apex, about a hand's breadth downward. It contained, at its apex, a cavity, containing pus, about the size of a filbert, and having a well-marked sac wall. In this vicinity, the lung was congested. No traces of tubercle.

On the right side, the removal of the sternum had opened the cavity anteriorly. It was, in diameter, about three fingers' breadths, enlarging a little as it passed backward behind the lung, and extended from the upper border of the fifth to the lower border of the eighth rib. The lung was compressed into a half-moon shape, the greater part being above the cavity, and firmly adherent to the side of the thorax; the middle portion was adherent to the pericardium, and a small portion was below the cavity, adherent to the diaphragm and wall of thorax. The diaphragm was pushed very high up, its apex being on a level with the fifth rib anteriorly. The adhesions of this lung were very firm, and the lung had to be dissected out. When removed, it was slightly larger than the heart, and pretty firmly hepatized. No trace of tubercle found.

The liver was considerably enlarged. On attempting to remove it, adhesions were found between the right lobe and the diaphragm; these were easily broken with the finger, and the liver removed. In the posterior part of the right lobe were two abscesses, about the size of an English walnut, and, an inch deeper in the substance of the lobe, two other similar ones. A fifth, rather larger than these, existed in

the anterior portion of the lobe. The abscesses had a ragged appearance, were lined by pretty firm walls, and contained dirty, greenish pus. Gall bladder was entirely empty. Kidneys normal. Rest of organs not examined.

A probe was passed through the small opening, which remained after the second operation, and was seen to come upon the lowest part of the diaphragm, but no opening could be found between the pleural cavity and that of the abdomen.

Among the details of this case, I should like to call attention to the following points:—

The condition of the patient; the long duration of the disease, the excessive sweating, painful bed-sores, and general prostration rendering it a most unfavorable case for operation.

The immediate relief and gain in strength which followed the evacuation of the pus, the general condition steadily improving up to about two weeks before his death.

The rapidity with which the large incision granulated together, which shows the necessity of guarding against this at the time of operation, by stuffing with lint, or inserting tubes.

The absence of tubercular deposit in the lungs after so much inflammatory disturbance.

The point selected for operation. At the second operation, when no pus could be evacuated, the tube was thrust in four or five inches, entering between the eighth and ninth ribs, about an inch external to the lower angle of the scapula. It probably passed below the small portion of lung adherent below the abscess and ascended upon the diaphragm. The autopsy showed that this point was nearly two inches too low to enter the cavity. The physical signs were the same as those higher up, and there was, apparently, bulging of the intercostal spaces. This fact shows that it is not *always* safe to enter the thorax very low down. The incision made at the next operation was visible for about two-thirds of its extent, as the patient lay upon his back, and could be easily reached without disturbing him.

The abscesses in the liver did not appear to be very recent, being lined by well-marked walls, but as they were not connected with each other, and as no fistulous track appeared, leading from them to the pleural cavity, I suppose that they were caused by septic poisoning. The general symptoms and appearance of the patient during the two weeks previous to his death were similar to those of pyæmia, although there were no successive chills.

FOUR AT A BIRTH.—A negro woman in Berlin, Ind., aged 40, recently gave birth to four well-developed children, three girls and one boy, one of the girls being still-born. There were two placentæ; three of the children were attached to one, while the dead one was attached alone to the other. No physician was present during her labor.—*Philadelphia Medical Times.*

MONSTROSITY.—At a recent meeting of the *Académie de Médecine*, M. Blot reported a case of monstrosity by the absence of the head, the chest, the greater part of the abdominal organs and the muscular system. The bones of the pelvis and the lower limbs, covered with skin, appeared to constitute the entire fœtus.

Clinical Lecture.

OVARIAN CYST.

By Calvin Ellis, M.D.,

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The patient is a married woman, 53 years old, who has always enjoyed good health and has borne four children, the youngest of whom is 22 years of age.

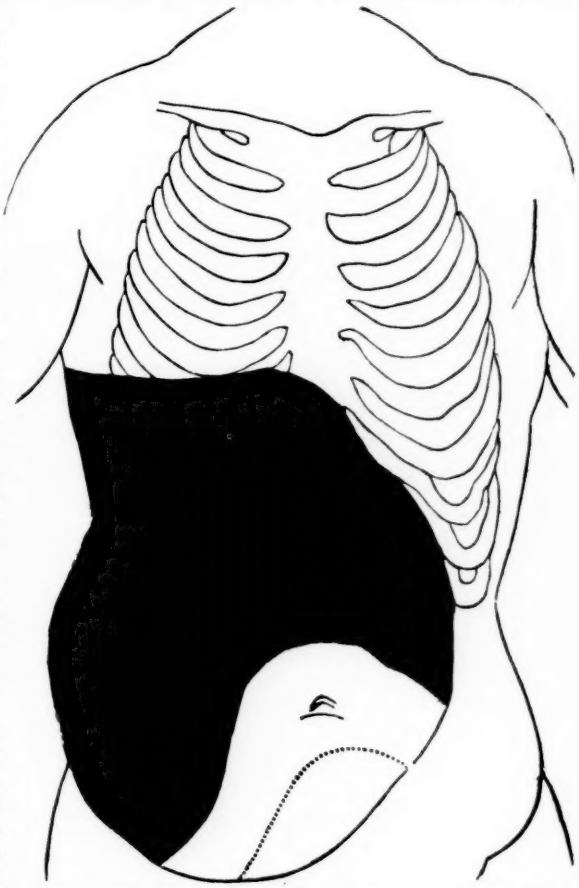
Twenty years ago, she first noticed a small *swelling in the right side of the abdomen*. This increased but little after the first year, but the *abdomen began to swell generally*, and has continued to enlarge up to the present time, particularly within the last three months. She complains of no pain or other abdominal symptoms, except distention. No *thoracic* symptoms have attracted attention. The *appetite* has been poor. The *bowels* have generally been constipated. *Micturition* has been normal, as well as the appearance of the *urine*. The *catamenia* were regular until she came to this country, twenty years ago, when they ceased, and have not since returned. During the past year, the *weight* has diminished and the *strength* has failed. She *sleeps* sufficiently well. The *tongue* is natural, the *pulse* 108.

We have here another history of *abdominal enlargement*, without such accompanying symptoms as enable us to form any opinion whatever about its exact seat or character. The fact that the *catamenia ceased at the age of* 32 has no special significance, in the absence of any constitutional disturbance. The menopause has been noticed at a much earlier age than this. Although there may have been some special cause in our patient we do not need such, and nothing indicates it in the history which she has given us. We can only say that the disease is *chronic*, and use our own senses to carry us farther.

We must, therefore, *examine the abdomen* at once to obtain material for a differential diagnosis. On *inspection* [see diagram, next page], we are at once struck with the marked *enlargement* which involves the whole abdomen, though the right lumbar region is particularly prominent, and there are *other irregularities of surface* in the lower half in the neighborhood of the umbilicus. The large prominence is perhaps six inches in diameter, while the others, in size and form, suggest a loop of intestine. But the eye can only suggest. We may say, however, that obesity cannot be the cause of the change of form; we may also say that these local prominences are not connected with any affection of the parietes themselves, that they are probably to be traced directly to the disease which has caused the general enlargement. The tension of the abdominal walls is such as to lead to the belief that the change of form is owing to *some affection within the peritoneal cavity*. I will also call your attention to the *undue fulness of the superficial abdominal veins*. This is frequently seen when the circulation through the deep-seated veins is interfered with, and the pressure of some large body in the peritoneal cavity might prove a sufficient cause.

Although the surface appears to be quite uniform, we notice that the *resistance to pressure varies in different parts*, and we must resort

to *percussion* to ascertain more correctly upon what this variation depends. The *perfect flatness* of the greater part of the abdomen, including the projection on the right side, contrasting strongly with the adjacent resonance, shows that *something has displaced the intestines*, for we cannot believe that the latter could have been so transformed as to give a sound so different from that met with in health. Percussion over the prominence in the right lumbar region giving precisely the same note as that over the adjacent portions of the abdomen, we may fairly infer that we have only different parts of one body. But the *percussion over the elongated prominence* in the lower part of the abdomen is very resonant. The character of this resonance is that of the intestine, and alternate pressure with both hands is accompanied by that peculiar gurgling sound caused by the movement of air and fluid in the intestinal canal. The form of this prominence, with the other peculiarities mentioned, indicates clearly the presence of a *loop or of loops of intestine*. Deep pressure here shows that the *intestine lies upon a firm body beneath it*, which may be traced until it completes the curved line of the left side of the abdominal mass, and gives to the whole an evenly rounded form, as shown by the line in the diagram.



We have, therefore, a large rounded tumor, filling the whole of the right and a portion of the left side of the abdomen, with some loops of intestine overlying if not adherent to it. You will also notice that the upper boundary of the flatness corresponds with that of the upper surface of the liver when in its normal seat, and may properly infer that while the new formation is in contact with, or may form a part of the liver, it has not displaced it.

The next question to determine is the *point of origin and true con-*

nection of the tumor, as its size and position oblige us to consider various parts, for, though continuous with the liver, it is lost in the pelvis.

We have already spoken of the significance of the early disappearance of the catamenia; we can base no diagnosis upon that. An examination of the *urine*, it is true, shows a deviation from the normal condition; the specific gravity is but 1·015, and there is a very small amount of albumen, with some crystals of oxalate of lime. Such modifications, however, have no necessary bearing upon disease of the kidneys themselves, and may be merely secondary. With these exceptions, there are no symptoms which call our attention to any particular organ. We will, therefore, *endeavor to ascertain its character*, and, this being determined, we may perhaps decide upon its seat.

We know that it is flat on percussion already; we know that it is bounded by a uniform curved line and is in contact with the intestines, a portion of which rest upon it. Its elasticity is such that we have reason to suspect a fluid, but we know that this peculiarity belongs to soft solids as well as fluids. By the ordinary test, we detect *marked fluctuation*, so characteristic that there can be no reasonable doubt about the presence of *fluid*. Considering the size, position and uniform outline of the mass, we must conclude that this fluid is contained within a sac; that we have a *cyst*, projecting into and occupying a large portion of the peritoneal cavity. *What is the character* of this cyst?

Such may form in the organs or adjacent tissues. It may be owing to the presence of *echinococci in the liver or elsewhere*, be connected with the *kidneys*, or with the *uterus or its appendages*. The patient tells us that she first noticed the tumor on the right side of the abdomen, but its exact position cannot be ascertained. Its absolute continuity with the liver, as shown by percussion, obliges us to give that organ full consideration. The complete flatness of the right side of the abdomen suggests the possibility that the intestines have been gradually displaced by some body extending from above downwards. But we must bear in mind, also, the possibility that so large a mass might compress the ascending colon to such an extent as to force out the air and deprive us of this evidence of the position of the intestine. But this point is not material, as a tumor, whether originating above or below, could enlarge without displacing that particular portion of the large intestine. If the liver be the seat of the growth, its size and form would indicate an echinococcus cyst, and the liver is as likely to form the nidus of the parasite as any other portion of the body. But such a disease is rare, and we should not be justified in diagnosticating it until we have considered and eliminated other organs which might be involved.

Cysts are met with in the *kidneys*, but the size alone would deter us from fixing the disease here. The *uterus* may be the seat of *fibro-cystic growths*; the *Fallopian tubes* may be *dilated* by an accumulation of *fluid*, or the *ovaries* may be the seat of *cystic formations* varying much in character.

Of these, cysts connected with fibroid growths of the uterus could not be expected to attain such a size; neither would the cysts of the Fallopian tubes, while such would be common in connection with the ovaries, and, enlarging upwards, would readily reach the liver. We

can, however, obtain additional information about the condition of the uterus by a vaginal examination. The latter shows that the organ is small, movable, and in its natural position. Though distention and displacements may be caused by ovarian cysts, such changes of form and position are much more likely to be connected with fibroid growths; and, taking the results of the examination in connection with the other facts, we must consider ovarian disease much the most probable.

It might be objected that, as a sac thus formed has necessarily a slender pedicle, and as the tumor before us does not fill the abdominal cavity, it should be movable. But it is well known that adhesions may form and prevent such mobility. But we have not yet excluded echinococcus cyst of the liver, and we cannot do so absolutely, although the character of the fluctuation and the relative frequency of the two diseases would lead us to decide in favor of the ovarian cyst.

Having made this *probable diagnosis*, we will resort to the *aspirator*, which ought to furnish us with conclusive evidence.

The fluid removed is opaque and of a brownish color. One familiar with the contents of ovarian cysts, would say at once that such a fluid indicated the presence of a formation of that character, but we may obtain still stronger evidence from a microscopic examination. We see in the field granular corpuscles resembling those of pus or epithelial nuclei, some of a larger size, of no definite character, and cholesterine. Though these elements are not absolutely characteristic, they are what we meet with in ovarian cysts, and there is an absence of any indication of the echinococcus. We may, therefore, consider the *diagnosis of an ovarian cyst established.*

Prognosis.—The prognosis, as far as the natural course of the disease has a bearing upon it, is unfavorable; and, considering the age and general condition of the patient, which unfit her for radical treatment, we cannot expect anything more than relief.

Treatment.—As the tendency is to persist and increase, we must interfere if possible. As no constitutional treatment has any effect upon the growth of a tumor of the kind, we must use surgical means. As the age and condition of the woman will not allow the removal of the growth, and as she suffers much from the distention, we must give relief by the operation of tapping. If it should be thought advisable to remove the cyst at a later period, it can be done. Some have objected to tapping, as it may excite inflammation and adhesion between the outer surface of the sac and the peritoneum, and thus interfere with the success of a subsequent operation, but experience has shown that if such an adhesion do take place no great harm follows. But it is not at all probable that our patient will ever be a fit subject for such an operation; she must be relieved, and tapping is our only resource. The use of a small trocar and the air-pump will reduce to a minimum any chance of injury.

By these means, fourteen quarts of the same brown liquid previously mentioned have been removed, with great relief to the patient.

The collapsed condition of the abdomen gives us an excellent opportunity to examine more thoroughly and ascertain whether the cyst be multilocular or not, for all of the above fluid has been drawn from a single cavity without changing the position of the trocar.

Such an examination shows, on the right side of the abdomen, where the projection was originally noticed, a solid, regular, flattened mass,

three or four inches in its transverse and six inches in its vertical diameter. Considering the form and feel of this, we have either a congeries of cysts containing fluid or a firmer fibro-cystic mass, perhaps containing colloid matter.

There only remains for us to better, as far as possible, the general condition of the patient by proper care and nourishment, and enable her to bear the returning discomfort which the re-accumulation of the contents of the sac will certainly produce.

LIFE SUSTAINED BY NUTRITIVE ENEMATA FOR A PERIOD OF TWENTY-TWO DAYS.—At the last meeting of the Bristol North District Medical Society, Dr. J. B. Whitaker, of Fall River, Mass., reported the following case:—

A strong, muscular man, 32 years of age, strictly temperate in all his habits, on the 3d day of May last, drank, by mistake, about three ounces of very strong, caustic potash lye. Antidotes were administered as soon as possible, but the injury was so severe that for thirty-nine days the patient could swallow only the most dilute liquids, and nutrition was aided by injections of beef-tea, gruel, &c. At the expiration of this time, a complete stricture of the œsophagus was formed, which prevented all attempts at deglutition for twenty-two days following. Efforts were made to overcome the stricture by the use of bougies, but not even the smallest could be passed. The patient was seen by Dr. Knight, of Boston, in consultation; and after a careful examination with the laryngoscope, and vain attempts to pass an instrument through the stricture, an unfavorable prognosis was given. Subsequent efforts, however, to dilate the stricture were successful, and a small bougie was passed into the stomach, after which a larger one, so that the patient could swallow fluids, and was improving satisfactorily. Subsequently, an attack of pleuro-pneumonia set in, from which he died seven days after the stricture had been overcome. The following is a summary of the case: Thirty-nine days supervened from the time of the accident to the formation of a complete stricture of the œsophagus. For *twenty-two days, the patient was wholly sustained by nutritive enemata;* and for seven days previous to his death he was able to swallow liquid nourishment, with tolerable freedom.

DR. HAMMOND'S DEFENCE.—Dr. Hammond has published, in the *New York Medical Journal* for September, a very elaborate defence of his action in regard to the McCormick case. The line of defence is that there are certain subjects connected with medicine in which the public are especially interested, and upon which they desire information; and, further, that men of excellent standing in the New York and even in the Philadelphia profession have frequently gratified this desire of the laity for knowledge. . . . . How different in tone from Dr. Hammond's defence—which says in substance, "I allowed it; I furnished the wood-cuts to the newspapers; but the rest of you do the same thing"—is the recent indignant disavowal by Prof. Paget of any collusion with the publication of one of his lectures in the *Pictorial World!*—a disavowal in which he declares that he did all he could to prevent the publication, and adds, "I venture to hope that I am not thought likely to be guilty of encouraging the appearance of my name newspapers."

Is further comment needed? Will libel suits and indulging in the schoolboy wit of calling editors names render the difference between these two courses less apparent?—*Philadelphia Medical Times.*

Progress in Medicine.

REPORT ON PATHOLOGY AND PATHOLOGICAL ANATOMY.

By R. H. Fitz, M.D.

(Concluded from page 377.)

Pathological Anatomy.

Fatty Emboli of the Lungs.—That embolism from oil globules might occur in the pulmonary as well as in the general circulation, has long been recognized. Experiments have shown that the intra-venous injection of large quantities of oil would produce death within a few minutes, while that of smaller quantities would give rise to death within a few hours, apparently due to œdema of the lungs. The case of Wagner and the subsequent experiments of Busch have directed a closer attention to this subject, and have been of great influence in suggesting a rational theory for the cause of death in a certain number of those cases of severe injury where such has been attributed simply to "shock."

Wagner's case was that of a man whose thigh was broken. Death afterwards occurred, preceded by coma, and many of the capillaries in different parts of the body were found to be plugged with oil globules. Investigating the matter experimentally, Busch found that, after breaking bones and crushing the marrow, fat drops were set free and were apparently taken up by the veins. They were then carried to the lungs and obstructed the pulmonary capillaries, producing death by œdema of these organs.

Bergmann (*Berliner Klinische Wochenschrift*, 1873, No. 33) adds another case to the series. His patient fell from a height of thirty feet; there resulted a comminuted fracture of the thigh. After a short time, pain in the chest was complained of; later, a frothy, bloody expectoration was ejected, the respiration increased in frequency, the lips became livid, the temperature rose, and fine moist râles were heard throughout both chests. Bergmann made a diagnosis of acute œdema of the lungs, caused by fatty emboli, eliminating traumatic pneumonia and pulmonary hæmorrhage. Death occurred seventy-nine hours after the accident. At the autopsy, both lungs were found to be hyperæmic, œdematous, dotted with small dark spots, and containing hæmorrhagic infarcts of the size of a pin's head.

The microscope showed the arteries and capillaries to be filled to an extreme degree with liquid fat. The broken bones were very much comminuted, the marrow crushed, and free fat, mixed with blood, was found at the seat of fracture.

Fatty embolism may occur in other ways, as is shown by a communication from Egli (*Untersuchungen aus dem pathologischen Institut zu Zürich. Jahresbericht der Gesammten Medecin*, 1873, p. 214). He reports two cases where fat was found in the pulmonary vessels in the form of drops and cylinders. In one case the condition was extreme, and he states that, during the last four or five days previous to death, the patient suffered from violent dyspnœa. The source of fat in these two cases was considered to be thrombi in the right heart, which had undergone puriform softening. The degenerated clots were found to

contain abundant fat drops, large and small. He suggests that the absence of fatty emboli in the general circulation might be due to the action of the heart being enfeebled to such a degree as to be unable to force the fat drops through the pulmonary capillaries.

Croup and Diphtheria.—As the term diphtheria, or diphtheritis, has become rather vague in the course of time, Senator (*Sammlung Klinischer Vorträge*, No. 78, 1874) would use the term "cynanche contagiosa" to designate an "acute, contagious disease, which occurs chiefly among children, usually beginning with fever, and producing certain alterations of the mucous membrane at the junction of the respiratory and digestive tracts, or in those parts of both tracts in the immediate vicinity of this place of union; that is, alterations of the mucous membrane of the tonsils, uvula and soft palate, base of the tongue, larynx and bronchi, the posterior wall of the pharynx or of the nasal cavity."

The local anatomical changes present numerous variations, dependent upon the quantity and condition of the contagium, possibly upon its stage of development, and upon the disposition of the patient or of the organ affected. A simple catarrh of the mucous membrane is the mildest expression; this may terminate in complete recovery within a few days. That this is no ordinary catarrh is to be inferred from its epidemic occurrence, often in the same house with the severer forms of cynanche. Further, the glands of the neck are usually swollen, and, lastly, it may be associated with the development of the severer forms.

There are, first, small round or longitudinal grayish-white, membrane-like patches seated upon the catarrhal portions of the mucous membrane, and which can readily be removed, thus disclosing an apparently unaltered mucous membrane. These patches rarely remain longer than a day, as convalescence or the more serious condition then follows. They are composed of tesselated epithelium, more or less altered, with which are found vegetable spores. It is of great importance that there is no evidence of an inflammatory process in these patches.

Finally, the remaining form also presents flat, grayish-white patches in the pharynx. These are more intimately connected with the mucous membrane beneath, and, when separated, are found to be merely the upper surface of a shallow ulcer, which extends superficially. Pain and slight bleeding are produced by attempts at their removal. The tissues beneath are infiltrated with cells, contain extravasated blood, while the superficial portions, the patches, represent dead bits of tissue, which are more or less loosely connected with the parts beneath. These patches are composed of epithelial cells of varying size and in various stages of destruction, of pus and blood corpuscles, of blood coloring matter; also of granular detritus and spores. They are rather to be compared with the gangrenous masses from a bed-sore, and the process giving rise to them is best called an acute gangrene or diphtheritic inflammation.

The transition between this stage and the preceding is a gradual one and may be overlooked; at the same time, it is not essential that the epithelial patches should have preceded, more particularly where the disease is violent and progresses more rapidly.

Putrefaction readily takes place at the seat of the inflammation, and

may advance to such a degree as to give a most marked instance of moist or putrid gangrene. This is to be considered merely as a higher degree of the diphtheritic form.

In the larynx, trachea and larger bronchi, the epidemic of cynanche likewise produces a catarrhal and diphtheritic inflammation. The latter occurs almost exclusively in the upper part of the larynx, as far down as the true vocal cords, and on the epiglottis. The anatomical structure of these parts, as well as the rapidly fatal result in general, prevent such deep destruction as is found in the tonsils. The epithelial false membrane is not found in the air passages, owing to the delicate nature of the cells there, especially of the ciliated epithelium, which is never detached in continuous masses.

In the air-passages, however, the fibrinous or croupous false membrane is found, which seldom if ever occurs in the pharynx. This is essentially composed of a coagulated albuminate, so-called fibrine, pus corpuscles, and an occasional red blood corpuscle. The absence of epithelium and spores is notable. If this croupous membrane is fresh, scarcely any spores are found. The mucous membrane beneath it is apparently unaltered. The epithelial layer may often be recognized, though at times it is wanting. The deeper layers of the mucous membrane are infiltrated with pus corpuscles, but there is no extravasated blood.

The anatomical alterations produced by cynanche contagiosa are these: catarrh, epithelial shreds only in the pharynx, diphtheritic patches from diphtheritic inflammation above the vocal cords, and fibrinous false membranes from croupous inflammation in the respiratory tract below the vocal cords.

During the epidemic of cynanche, and dependent upon it, there has been observed a diphtheritic inflammation of other mucous membranes —of the conjunctiva, for instance, or of the genital mucous membrane. It is not, therefore, to be concluded that every diphtheritic inflammation of these membranes, even when endemic, is due to the cynanche. A diphtheritic inflammation may occur upon the surface of any wound or ulcer, under certain local or general conditions. In cynanche, it is the rule for these different forms of inflammation to occur side by side and to run into each other. When the child dies with cynanche, the *post-mortem* examination usually discloses membranous patches (diphtheritis) in the upper part of the larynx, the fibrinous exudation (croup) lower down in the air passages, and, still further downwards, a catarrh. It is usually impossible to say where the croupous membrane ceases and the diphtheritic membrane begins; nor is it to be stated that the former represents a less, the latter a more severe result of the cause of the disease. The process usually begins on the tonsils, soft palate or posterior wall of the pharynx, and is very often limited to these parts. It is very rare for the larynx to become affected without a previous inflammation, or a very rapid subsequent affection of the pharynx. The inflammation may extend from the pharynx into the nose or larynx, but rarely into the œsophagus. It may extend from the nasal cavity to the conjunctival mucous membrane. Senator does not absolutely reject the view that there may be a croup limited to the air-passages, and distinct from the cynanche or diphtheria. There seems no doubt that chemical irritants may produce a croupous inflammation of the

air-passages, and observers, up to a comparatively recent period, even now, state that in certain epidemics, while the air-passages are affected by the croupous inflammation, there is no alteration, whatsoever, of the pharynx. At the same time, he maintains that "in by far the greatest majority of all cases, at present, at least, the croupous inflammation of the larynx and air-passages is the result of the cynanche contagium, and occurs almost exclusively in epidemics of cynanche simultaneous with its other anatomical forms." Hence, in general, croup and diphtheria represent merely forms of one and the same disease, cynanche.

Senator regards it as indisputable that the contagious material of the disease is attached to the mucus, pus and shreds of tissue from the diseased parts of the throat, and as not improbable that the same is living and organized. At the same time, the micrococci found in this disease can in no way be distinguished from the organisms found in any putrefactive process, and their inoculation gives rise to no differing results; hence, they cannot be regarded as possessing any specific nature. The idea that the micrococci of putrefaction cause the cynanche, or that micrococci are the first and only cause of the disease, is opposed by the fact that they are not found in any quantity below the vocal cords. In addition, the disease almost never extends into the œsophagus, a road apparently so direct. Finally, the same anatomical alterations of the pharynx may occur in scarlatina and cynanche, while the alterations of the air-passages are very rare in the former disease.

It is considered quite probable, from reasons advanced, that the peculiar form of diptheritic inflammation is due to micrococci. Whenever diphtheritis occurs, the micrococci are found, almost without exception, and by inoculating an inflamed part with putrid material, containing micrococci, a diphtheritic inflammation may be produced. For the germs to become active, they must be sufficient in quantity, in a state of activity, and with a capacity for development, and the tissue must be capable of receiving them. In the pharynx, all these conditions are present. In the respiratory tract, the ciliary movement prevents the colonization of the micrococci, and the carbonic acid gas possesses antiseptic properties.

According to Senator, the unknown contagium of cynanche disposes to a violent inflammation of the parts affected, as that of scarlatina does to the pharyngeal mucous membrane, or that of measles to the mucous membrane of the larger air-passages, nose and eyes. As a result of the inflammation, the epithelium is loosened and elevated, and losses of substance occur. The spores, always abounding in the pharynx, enter the tissues, and give rise to the death of the inflamed, superficial layers, and the diphtheritis occurs. The latter is, therefore, secondary, and may follow other forms of pharyngeal affections, as in scarlatina, variola, syphilitic ulcers, &c. The diphtheritis once established, and the micrococci favored with so suitable a soil, the air may become readily infected by them, and every ulcer exposed to this air may readily become diphtheritic. There is no necessity, however, that the cynanche poison should be therewith transmitted.

Bibliographical Notices.

The Building of a Brain. By EDWARD H. CLARKE, M.D., Author of Sex in Education. Boston: James R. Osgood & Co. 1874. Pp. 153.

IT is not to be expected that this work should create an excitement similar to that which followed Sex in Education. Continuations and second parts almost invariably cause some disappointment, from the fact that they can only elaborate the original central idea. The scope of Dr. Clarke's former book may be stated in a few words: he argued that women are not men; not that they are inferior to them, but different, and that, owing to their special functions, the education of girls cannot be conducted on the same plan as that of boys. Trite and indisputable as these statements must appear, it was curious to observe that a certain class, far from looking on them as truisms, were inclined to find in them the deepest insult to the sex, and the greatest disparagement of it. The reception of the book, both by friends and foes, shows how much it was needed.

In the present work, the question is approached rather differently, but the object is the same. The book is divided into three parts; the first, which was read last summer before the National Educational Association, is entitled "Nature's Working Plans;" the second, an "Error in Female Building," is cumulative evidence in support of the views advanced in "Sex in Education," containing the opinions of many well fitted to speak on such matters, and the sad details of the case of an ambitious and not unhealthy girl, whose death was traced to over-study. The third part, a "Glimpse at English Brain-building," is a striking picture of the care with which girls are brought up in England, the absence of excitement, and the attention to health.

The first part is the essential one of the book; and we regret that we find in it much to criticize. We regret this, for we are quite in accord with the author as to his conclusions, and we fear that a captious and unfriendly critic may direct attention from these just conclusions to what we believe to be errors in the physiological argument. We will quote Dr. Clarke's statement of the way in which he uses the word *brain* (which is made to include the whole nervous system). "First, brain is used as the correlative of mind, not from a materialistic point of view, as if mind (including volition) and brain were identical, but because we know, and only can know, the mind through the brain. The quantity and quality of the latter determine for us the quantity and quality of the former. The development of the soul and mind—of the *ego*—resolves itself into the development of the brain. The artist who builds a fountain looks carefully after the strength and structure, the quality and form, of what he builds, and troubles himself very little about the water which is to animate his work. He knows that jet and drop and spray will pour out just as the fountain permits the flow. In proportion to the character of its structure will be the manifestation of mind and spirit through it. Build the brain aright, and the Divine Spirit will inhabit and use it. Build it wrongly, and the Devil will employ it. The development of the mind, then, means, practically, the development of the brain; and the building of a brain is a part of education" (p. 23). As to the problems before us, they are two, "first to develope the individual to the highest degree; and, secondly, to obtain this development without interfering with the perpetuation of the best. In other words, humanity demands, and our education must give, both the highest development of the individual, and the perpetuation of individuals thus developed, or, as it is commonly expressed, the perpetuation of the fittest. It has been argued, with much apparent force, that these two results are impossible, because the highest cerebral development, being made at the expense of the rest of the organism, sterilizes the individuals whose brains attain such supposed magnificent proportion and quality. This is not the place, nor does it fall in the scope of this paper,

to point out the fallacy of such a statement. It is referred to only for the purpose of calling attention to a physiological error that has already been grafted into our system of education, and which exerts the most pernicious influence in our common and high schools, viz., the error of exclusively developing one part of the organization at the expense of and by ignoring the rest" (p. 15). The author considers such development abnormal, and says, further on, "No perfect brain ever crowns an imperfectly developed body." Now we can hardly assent to the compromise made between the religious and materialistic doctrines; we imagine it would be equally unsatisfactory to Prof. Tyndall, and to his adversary, Dr. McCosh. Had the author taken the purely materialistic ground, his position would have been stronger, but as it is, the simile of the fountain is unfortunate. It is true that the water can be known only through the fountain, but only the shape assumed by the water is modified by it; it may be clear or turbid, fragrant or foul, carrying strength or infection as it falls in the same graceful curve, just as good or bad thoughts, pure or corrupt principles may be equally strongly, eloquently, convincingly expressed by a well-developed brain. It is true that for the water to do its office, good or bad, the fountain must be well built, but no perfection in its structure will change the character of the fluid flowing through it. Was it necessary to open the door to such an unprofitable discussion as the above remarks suggest? We think not.

Let us next consider what is the fittest type of man. Our author apparently says, one with all his parts well developed and in perfect relation to each other; and he implies that greater perfection is synonymous with greater development so long as the proportions are not disturbed. Granted, that if the world were peopled with such creatures the average would be improved, the result, none the less, would be the apotheosis of mediocrity. Dogs shall furnish us an example. We have some excellent for swiftness, some for strength, some for keenness of scent, some for their affection, &c. &c., and by judicious crossing two or more of these excellencies may be combined. Now it may be said that when any of these qualities is excessive it is at the expense of others, that the strength of the bull-dog is at the expense of his speed, &c., but who would be content to relinquish all extremes of excellence and to have dogs neither very swift, nor very strong, nor very keen scented, nor very affectionate, but possessing all these qualities in a moderate degree? Whatever makes any given dog particularly valuable would be lost. If it be true, as Dr. Clarke supposes, that the human brain of to-day will be to that of the distant future, "as the lenses of two hundred years ago are to those of the present day," we are sure that it will not occur through the perpetuation of faultless insignificance. Even if the rule were universal that extraordinary development of one part, say the brain, renders the individual sterile, it may still be occasionally desirable. Though the family perish, ideas may live and have an effect on future generations, not for evil only, as the author implies, but for good also. We do not remember whether Isaac Newton had children or not, but even if he had, it is as a mathematician, not as a breeder, that he has claims on our gratitude.

Again we cannot accept without question the dictum that "no perfect brain ever crowns an imperfectly developed body." Let the reader recall a number of the best brains he can, and count up how many of them were or are in sound and perfect bodies, or, what is more striking, let him test the converse by thinking of a number of the best developed bodies (excluding cases of excessive development), and tell us how many of them are crowned with proportionately developed brains.

We admit the fitness of Dr. Clarke's ideal of a man to recruit the rank and file, but for leaders in the various arts and sciences, which are roads to progress, we must have those specially fitted for their respective pursuits. Far be it from us, moreover, to undervalue education, or to dispute that there is an intimate relation between the brain and the other organs, and that the nature of the brain, the health, character and future of the individual depend largely upon education. Our dissent from some of the author's physiological and social theories does not in any way prevent us from accepting the point

on which he strongly dwells—namely, that though the sexes are different merely in sex, the difference for the most elementary reasons, necessitates, at least after a certain age, their separate education. "But this identity of method in cerebral architecture, which requires that every organ and function in both sexes should have appropriate development and exercise, as a part of brain-building, implies, or rather necessitates, a difference in education between the sexes, just so far as there is a difference of organization and no farther. Identical education of the sexes is in the last analysis equivalent to an unjust discrimination between them: their appropriate and consequently different education is equivalent to the same method of brain-building" (p. 51). "The stimulus of emulation, of constant, daily competitive work, affects the two sexes differently during the epoch of development. A boy is less susceptible to this stimulus at that time than a girl; so that when the same stimulus is applied to the two sexes, at the same time and in the same way, if enough of it is applied to keep a boy well up, it is a physiological injury to a girl; if only enough is applied to keep her properly at work, the result is a physiological injury to him" (p. 63). We must allow ourselves one or two more short quotations as examples of the wisdom of the practical part of the work and of the clear and forcible style in which it is presented. "It is as unphysiological and fraught with danger to make the brain work over books, before its tissue is ready for that sort of cerebration, as to coax a baby to stand, before the bones of its legs are stiff enough to hold up the body" (p. 45). And again, when explaining that he would not be understood to advise that the attention of the young should be directed to their organs and functions, the author says, "one, whose brain ever watches his stomach, is sure to generate a worse dyspepsia there than ever hot bread or unnatural luncheons caused" (p. 47).

We believe the book will do much good, and our criticism is, that, as the conclusions could have been reached by a much simpler line of argument, based on indisputable physiological facts, it was a mistake to introduce theories still open to discussion.

BOOKS AND PAMPHLETS RECEIVED.

Clinical Lectures on Diseases of the Nervous System. By Wm. A. Hammond, M.D. Reported, edited, &c. by T. M. B. Cross, M.D. New York: D. Appleton & Co. 1874. Pp. 287. (From A. Williams & Co.)

Essentials of the Principles and Practice of Medicine. By Henry Hartshorne, M.D. Fourth edition. Philadelphia: Henry C. Lea. 1874. Pp. 547.

Tinnitus Aurium. By Laurence Turnbull, M.D. Reprinted from the Philadelphia Medical Times. 1874. Pp. 16.

On Deaf-Mutism and the Method of Educating the Deaf and Dumb. By Laurence Turnbull, M.D. From the Transactions of the Medical Society of the State of Pennsylvania. 1874. Pp. 7.

Erysipelas and Childbed Fever. By Thomas C. Minor, M.D. Cincinnati: Robt. Clarke & Co. 1874. Pp. 131.

Code of Ethics, Constitution and By-Laws of the Kansas State Dental Association, adopted May 5, 1874. Pp. 14.

Annual Report of the Kansas State Dental Association. 1874.

The Physicians' Visiting List for 1875. Philadelphia: Lindsay & Blakiston. (For sale by A. Williams & Co.)

Infant Diet. By A. Jacobi, M.D. Revised, enlarged and adapted to popular use by Mary Putnam Jacobi, M.D. New York: G. P. Putnam's Sons. 1874. Pp. 119. (From A. Williams & Co.)

Erysipelas, its Treatment with Sulphate of Quinine. By Y. R. LeMonnier, M.D. From the New Orleans Medical and Surgical Journal, November, 1874.

Biennial Report of the Officers of the Vermont Asylum for the Insane for the two years ending August, 1874. Pp. 56.

Boston Medical and Surgical Journal.

Boston: Thursday, October 22, 1874.

In answer to a call, signed by a number of prominent gentlemen, which appeared in the papers yesterday, a public meeting will be held to-day, at half past ten, in Horticultural Hall, for the purpose of raising a large sum of money for a new building for the Harvard Medical School. The Hon. J. H. Clifford will preside, and addresses are expected from President Eliot, Dr. Holmes, Dr. E. H. Clarke, and the Rev. E. E. Hale. The signers of the call are Messrs. Henry P. Kidder, Martin Brimmer, J. Ingersoll Bowditch, Nathaniel Thayer, Henry L. Pierce, John A. Lowell, and Drs. Calvin Ellis, B. E. Cotting, and Charles E. Ware.

Though the history of the Medical School for the last few years is pretty well known, we must review it briefly, to show the claims of the institution. In 1871, the Faculty, tired of the unsatisfactory method of instruction, which is still retained in every other American school, decided, at no matter what pecuniary loss, to do its duty by the community, and to make a radical change in the course. The new plan abolished the dreary winter term, in which, from morning to night, the same lectures were forced in rapid succession upon the youngest and the oldest students, and demanded attendance throughout the whole academic year. Recitations and laboratory work were made of equal importance with lectures. Certain studies were allotted to each year, and the student was forced to pass a satisfactory examination in the majority of them, under penalty of falling into the succeeding class. A course for graduates has since been established for the benefit of those wishing to devote themselves to special branches, or to make original investigations. The Faculty met, at first, with no great encouragement; many did not believe that the time had come to raise the standard of education so high in this country; others, though approving of the movement, thought it must end disastrously, from want of funds. In spite of these gloomy forebodings, the attempt has met with complete success, and it has been shown that the effort was not premature. This year, already, about one hundred new students have begun the study of medicine. It is said that the college should have waited for an endowment, but, as President Eliot well remarked, in a speech on the subject at the dinner of the Medical Society, in 1873, the best way to obtain one is to deserve it. This has been done: the Harvard Medical School, from one of the first, has become the leading school in America, and, if we mistake not, ere long, still

further advances may be expected. What is now needed is money, not to fill any deficit, but to give the school proper accommodations. The building is entirely inadequate; every available inch has been converted into laboratories, and more are required. The building, surrounded by inflammable structures, is not thought fit to contain the valuable collection, much of which is stored elsewhere. The collection belonging to the Society for Medical Improvement will be transferred to Harvard as soon as there is a proper place to receive it. When we consider how much the school has accomplished without assistance, we hardly dare, lest we should be thought to exaggerate, to dilate on what might be expected, had it only the opportunity to carry out its desires. The country may be spared the reproach of seeing the richer graduates, who desire a perfect medical education, flock to foreign schools, while the poorer ones complain that, by being kept at home, they must start in the race for success with the drawback of insufficient training. Give it but the means, and the Harvard School will be the great medical educational centre of America.

We are glad to see that the matter has been taken up by the community in a way that promises the best results. The profession, we trust, will leave no stone unturned to assist in a work which must redound to its own honor. We most earnestly commend the project to all friends of education; in no other way can they do so much, not only to advance science, but to diffuse most generally its practical blessings.

At the regular meeting of the Boston Society for Medical Improvement, held on Monday, October 12th, on "Reports of Committees" being called for, Dr. D. H. Storer rose and said:—

"Mr. Chairman: At the last meeting of the Society, Drs. Jackson, Abbot and myself were appointed a committee to prepare resolutions which should express our sense of bereavement at the death of Jeffries Wyman. As chairman of the committee, it was expected and earnestly desired that Dr. Jackson should present these resolves; he, however, has requested me to perform this duty, and I could not refuse the opportunity to offer my sincere tribute to the memory of my departed friend.

"The Corporation of Harvard University, the trustees of the Peabody Museum, the American Academy of Arts and Sciences and the Boston Society of Natural History have each acknowledged their indebtedness, and expressed their gratitude. It is peculiarly appropriate that the members of a profession, of which he was a most honored associate, should add their voice to the universal lament. We would not utter one syllable of exaggerated praise; we would not insult the memory of our friend by a word of fulsome eulogy.

"In behalf of the committee, I offer the following resolutions:—

"*Resolved*, that, by the death of Jeffries Wyman, our Society has experienced an irreparable loss. Distinguished for the accuracy of his information in the department to which he was particularly devoted, we confidently applied to him to settle any doubtful question which might arise. His readiness, upon all occasions, to remove existing difficulties, his uniform courtesy, his modesty in expressing his opinions, his care never to detract from others' labors while reciting his own, caused him to be esteemed and admired.

"*Resolved*, that, while we thus honor his memory as a physician, we would recall, also, his *humanity;* we would dwell upon the purity of his every-day life; we would remember the depth and duration of his friendship; we would enshrine the man in our hearts.

"*Resolved*, that we extend our sympathy to his afflicted family, and transmit to them the above resolves."

These resolutions were unanimously carried, and the Secretary was instructed to publish them in the Boston Medical and Surgical Journal.

F. B. GREENOUGH, M.D.

BOSTON DISPENSARY.—The following are the statistics of this institution for the year ending September 30th, 1874. The number of new patients visiting the central office was 23,040. They are classified as follows:—

MEDICAL DEPARTMENT.

	Men.	*Women.*	*Children.*	*Total.*
1st quarter,	678	1477	867	3022
2d "	1075	1299	899	3273
3d "	1076	2014	1366	4456
4th "	1063	1734	2296	5093
Total,	3892	6523	5428	15,844

SURGICAL DEPARTMENT.

1st quarter,	329	235	120	684
2d "	378	210	148	736
3d "	413	278	232	923
4th "	372	234	196	802
Total,	1492	957	696	3145

DENTAL DEPARTMENT.

1st quarter,	107	156	149	412
2d "	107	128	216	451
3d "	123	150	238	511
4th "	128	197	255	580
Total,	465	631	858	1954

SKIN DEPARTMENT.

1st quarter,	152	138	111	401
2d "	132	96	179	407
3d "	185	140	127	452
4th "	177	184	214	575
Total,	646	558	631	1835

DEPARTMENT FOR DISEASES OF NERVOUS SYSTEM.

1st quarter	53	24	3	80
2d "	41	21	12	74
3d "	36	35	5	76
4th "	34	31	7	72
Total,	164	111	27	302

The number of patients visited at their homes by the District physicians is as follows:—

	Men.	*Women.*	*Children.*	*Total.*
1st quarter,	497	1154	1320	2971
2d "	662	1454	1504	3620
3d "	585	1298	1578	3461
4th "	557	1305	1716	3578
Total,	2301	5211	6118	13,630

RESULTS OF TREATMENT.

Discharged, cured or relieved, - - -	12,697
Sent to Hospitals, or removed from Districts,	555
Died, - - - - - - - - - -	372
Remaining under treatment, - - - - -	156
	13,780

Under treatment at last annual report,	150	
	13,630	
Number of cases treated at Central Office,	23,040	
Total treated at Central Office and in the Districts,	36,670	

PATIENTS, NEW AND OLD, AT CENTRAL OFFICE.

1st quarter,		10,603
2d "		10,755
3d "		12,436
4th "		13,448
Total		47,242
Number of cases of midwifery,	181	
Number of recipes,	75,510	
Daily average,	256	
Sunday average,	16	
Number of recipes since July, 1856,	831,871	
Number of patients since October, 1796,	519,641	
Number of patients since July, 1856,	399,839	
Average daily attendance of patients at Central Office,	153	

SURGEONS.

John Homans, M.D. — Samuel W. Langmaid, M.D.
J. Brackett Treadwell, M.D. — Thomas B. Curtis, M.D.

PHYSICIANS.

J. McLean Hayward, M.D. — Wm. L. Richardson, M.D.
Frederic I. Knight, M.D. — William E. Boardman, M.D.
Charles E. Inches, M.D. — Charles P. Putnam, M.D.
J. Franklin Appell, M.D. — Theodore W. Fisher, M.D.
Robert Disbrow, M.D. — Thomas Dwight, Jr., M.D.
Thos. Waterman, M.D. — Reginald H. Fitz, M.D.
Henry Tuck, M.D. — Josiah L. Hale, M.D.
W. H. H. Hastings, M.D. — William H. Baker, M.D.

DEPARTMENT FOR DISEASES OF THE NERVOUS SYSTEM.

Samuel G. Webber, M.D. — David F. Lincoln, M.D.

DEPARTMENT FOR DISEASES OF THE SKIN.

Francis B. Greenough, M.D.

DENTAL DEPARTMENT.

Forrest G. Eddy. — Jesse Robbins.

DISTRICT PHYSICIANS.

No. 1.—John B. Fulton, M.D. — No. 6.—Walter Channing, Jr., M.D.
No. 2.—Frederick W. Vogel, M.D. — No. 7.—James H. Davenport, M.D.
No. 3.—Amos L. Mason, M.D. — No. 8.—Wallace W. Lovejoy, M.D.
No. 4.—Francis A. Harris, M.D. — No. 9.—John G. Stanton, M.D.
No. 5.—Joseph P. Oliver, M.D.

John J. Kelley, Apothecary; Clarence W. Huntington, Assistant Apothecary.

ALFRED L. HASKINS, M.D., *Superintendent.*

Obituary.

DR. NATHANIEL BRADSTREET SHURTLEFF died of apoplexy on October 17th, in the sixty-fifth year of his age. He graduated at Harvard in 1831, and took his medical degree in 1834. He was gifted with a great taste for scientific, and still more for literary, pursuits. Besides being a member of various medical societies, he held a prominent position in many others, among which we may mention the Boston Society of Natural History, the American Academy of Arts and Sciences and the Massachusetts Historical Society. He was an honorary member of the Royal Society of Antiquaries, of London; and, for twenty-two years, he had been secretary of the Board of Overseers of Harvard College. He was Mayor of Boston in 1868, 1869 and 1870. He was the author of several works, chiefly historical. His death will be widely regretted.

Medical Miscellany.

We learn from Washington papers that Dr. Joseph Taber Johnson has been elected orator to the Society of the Alumni at the annual commencement of the Medical Department of Georgetown University next March.

Suppression of Urine for Twenty-five Days.—Dr. A. W. Fontaine narrates an instance of suppression of urine, lasting twenty-five days, occurring in a woman about twenty-one years of age, somewhat predisposed to hysteria, and the subject of some obscure spinal affection.—*Virginia Medical Monthly*, Oct., 1874.

Statistics have been recently collated in Bavaria with respect to the color of the eyes, hair and skin of school children. The first report, coming from Ausbach, gives the total number of children examined in this place at 1,517. Of these, 36 per cent. were found to have blue eyes, 30 per cent. grey and 34 per cent. brown. As regards the hair, 47 per cent. exhibited blond hair, 49 per cent. brown, and 4 per cent black. In 81 per cent., the skin was white, in 19 per cent., brown.

Idiopathic Rupture of the Spleen.—Mr. Edward Atkinson, of Leeds, reports a rare and interesting case of death from idiopathic rupture of the spleen, occurring in a lady, aged thirty-five, who had been subject to an irritable stomach, with occasional attacks of pain in the gastric region. She had experienced no very decided symptoms, however, until twenty hours previous to death. The character of the lesion was only revealed by an autopsy.—*British Medical Journal*, Sept. 26.

Perforation of the Rectum.—A young girl, fifteen years of age, in attempting to jump upon the knee of her uncle, came down upon a walking-stick, which she had not observed him to be holding between his legs. The end of the stick penetrated the anus. She withdrew the stick, and, though she complained of pain, was able to keep in good spirits for the rest of the day. On the following day, symptoms of acute peritonitis supervened, and, on examination by the attending surgeon, Dr. C. S. Jeaffreson, a rent was discovered in the anterior wall of the rectum, which was large enough to admit the finger into the peritoneal cavity at the apex of the recto-vaginal pouch. Death took place within forty-eight hours, and the site of the wound was verified by *post-mortem* examination.—*British Medical Journal*, September 26.

Mortality in Massachusetts.—*Deaths in seventeen Cities and Towns for the week ending October* 10, 1874.

Boston, 160; Worcester, 26; Lowell, 27; Milford, 2; Chelsea, 5; Cambridge, 13; Salem, 7; Lawrence, 8; Springfield, 10; Lynn, 12; Fitchburg, 2; Newburyport, 1; Somerville, 10; Fall River, 21; Haverhill, 5; Holyoke, 10; Pittsfield, 6. Total, 325.

Prevalent Diseases.—Consumption, 55; cholera infantum, 35; typhoid fever, 25; diarrhœa and dysentery, 12; pneumonia, 11.

CHAS. F. FOLSOM, M.D.
Secretary of the State Board of Health.

Deaths in Boston for the week ending Saturday, Oct. 17, 133. Males, 75; females, 58. Accident, 3; apoplexy, 5; inflammation of the bowels, 4; disease of the bowels, 1; bronchitis, 3; inflammation of the brain, 1; congestion of the brain, 1; disease of the brain, 2; cancer, 2; cholera infantum, 13; consumption, 24; cerebro-spinal meningitis, 1; convulsions, 2; debility, 5; diarrhœa, 5; dropsy of the brain, 3; drowned, 2; dysentery, 1; diphtheria, 1; diabetes, 1; erysipelas, 1; scarlet fever, 3; typhoid fever, 6; gastritis, 1; disease of the heart, 3; intussusception, 1; indigestion, 1; intemperance, 3; disease of the kidneys, 3; disease of the liver, 3; congestion of the lungs, 1; inflammation of the lungs, 6; marasmus, 3; old age, 2; paralysis, 4; pleurisy, 1; premature birth, 3; puerperal disease, 2; peritonitis, 2; suicide, 1; syphilis, 1; teething, 1; whooping cough, 1; unknown, 1.

Under 5 years of age, 53; between 5 and 20 years, 11; between 20 and 40 years, 38; between 40 and 60 years, 14; over 60 years, 18. Born in the United States, 94; Ireland, 22; other places, 17.